A. **Intake and screening.** This function consists of: the inital contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. **Assessment and reassessment.** During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. **Case management plan and coordination.** The activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, duration and cost of the case management services required by a particular recipient; selection of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes through case conferences an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;

2. the continuity of service;

3. the avoidance of duplication of service (including case management services); and,

4. the establishment of a comprehensive case management plan that addresses the interdiciplinary needs of the recipient.

D. **Implementation of the case management plan.** Implementation of the plan includes: securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. **Monitoring and follow-up.** The case manager is responsible for: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and, if the plan has been formulated by a practitioner advising the preparer of the case management plan of the findings; collecting data and documenting the progress of the recipient in the case record; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

   An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS.**

   An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. **Case management plan.** A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS.**

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred;

d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and

e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

3. **Continuity of service.** Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district*; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMRDD entity is not capable of serving clients in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best subsitute. Clients are free to choose among qualified providers within the State.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving instititutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligiblity determinations/redeterminations;

3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNF's, ICF's and ICF/MR's; and

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "B"

A minimum of monthly case contact will be required in all cases with the following exception. For persons residing with their families, the required monthly contact may be waived, with a minimum of quarterly contact maintenance instead, where:

1. the client is a child who attends a residential school during the school term and requires comprehensive service only part of the year, or

2. the family has requested less frequent contact and the case manager has determined that this is appropriate.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services, who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. State and local governmental agencies; and

d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS,** including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS,** including the performance of assessments and development of case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "B"

1. Providers

Providers of Comprehensive Medicaid Case Management to developmentally disabled persons in Target Group "B" shall only be the Borough/District Developmental Services Offices (B/DDSO) of OMRDD and voluntary non-profit agencies and organizations authorized by OMRDD as CMCM/OMRDD providers, and identified by OMRDD to SDSS.

2. Case Managers

Case managers serving Target Group "B" must meet the minimum qualifications described above.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group:

90-42

See attached Target Group C

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. Target Group C

This target group consists of any categorically needy or medically needy individual who meets one or more of the following criteria:

1. All HIV infected persons;

2. All HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; and

3. All high risk individuals for a temporary period of time not to exceed 6 months with transition to another appropriate case management program for individuals who are HIV negative or continued unknown status. High risk individuals as the term is used in the expanded target Group C AIDS CMCM population are those individuals who are members of the following category:

   Men who have sex with men (MSM), substance abusers, persons with history of sexually transmitted diseases, sex workers, bisexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex --with HIV+ or high risk individuals.

Family members and coresidents (ie. collaterals) of the above targeted index clients may also receive case management services as necessary, to allow for the provision of necessary care and services to the targeted individual. Services for case collaterals shall be considered as one family unit in the case manager's caseload. Separate assessments and service plans are not required for collaterals, but may be incorporated into the case records of the primary client. Collaterals may have services arranged for by the case management provider. Case management services for collaterals should be limited to issues that directly affect the care of and services to the primary client.

The clients targeted under this proposal face enormous barriers to care, such as continuing drug and alcohol use, and their associated medical and social problems, domestic violence, mistrust of medical care and other services, fear of losing their children to foster care, fear of HIV infection and its consequences, lack of transportation and day care services, and lack of support in accessing care for their sexual partner and/or coresidents. These barriers to care can be overcome by the persistent efforts of indigenous community follow-up workers in cooperation with case managers. These workers must have special skills and strengths to deal with these problems, to win the trust and confidence of their clients in order to motivate them to return to care and to be continuously monitored thereafter. The magnitude of the effort required to accomplish this exceeds the capabilities of existing institutional bound and community case managers and requires the extensive frequent personal contact possible through an intensive case management program under Comprehensive Medicaid Case Management.

B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED

90-42

Services to this target group may be provided statewide.

C. COMPARABILITY OF SERVICES

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. DEFINITION OF CASE MANAGEMENT UNDER THE COMMUNITY FOLLOW-UP PROGRAM (CFP)

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

Case management is a multi-step process comprised of the following activities:

1. Intake
2. Assessment
3. Initial Care Plan Development
4. Initial Care Plan Implementation
5. Reassessment
6. Care Plan Update
7. Care Plan Update Implementation
8. Monitoring
9. Crisis Intervention Activities
10. Termination/Case Disposition Activities
11. Client Advocacy, Interagency Coordination and Systems Development Activities
12. Supervisory Review/Case Conferencing

The sections below describe the specific functions in detail.

1. Intake

The case manager should collect identifying information concerning the client, family, care givers and informal supports including the intake elements required on forms developed or approved by the State Department of Health. A list of family members, coresidents and children not currently living at home should be recorded including identification of the primary caregiver, primary contacts and legal guardian(s) of the child(ren). Client consent to case management, including home visitation, case conferencing, service acquisition and registration procedures, should be obtained and documented in the case records.